Arizona's Community Based Services and Settings Report

(3rd Biennial)

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PREFACE

Tri-Agency Committee

The Arizona Community Services and Settings Report is the product of a goal established by the Tri-Agency Committee on aging issues which is "to collaborate on data collection research."

The Arizona Health Care Cost Containment System (AHCCCS), Arizona Department of Economic Security (DES), and the Arizona Department of Health Services (ADHS) formed the Tri-Agency Committee in FY 2001 to strengthen collaborative efforts on aging issues. The mission of the Tri-Agency Committee is to provide leadership to improve the lives of Arizona's aging population by:

- Coordinating communication among the aging programs at the ADES, ADHS and AHCCCS;
- Integrating procedures among the aging population programs at the DES, DHS, and AHCCCS;
- Improving public access to information that is of concern to older adults; and
- Providing mutual support for individual agency's aging initiatives.

Team Members

The team members represent the aging programs, strategic planning, public information and policy areas for their respective agencies. The members are responsible for reporting progress to the directors of the agencies. The members and agency affiliations are as follows:

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Prepared by:

A sub-team was formed to prepare this report. Below is the list of the sub-team-members who prepared the 2002 HCBS report, and their agencies.

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Report Summary

What is the Community Based Report?

The Community Based Services and Settings Report is a collaborative effort of the Arizona Health Care Cost Containment System (AHCCCS), the Department of Economic Security (ADES), and the Arizona Department of Health Services (ADHS). The report consists of the following:

- Data, trends and findings from Arizona's two major long term care home and community based services (HCBS) programs;
- General national and state trends in HCBS;
- Accomplishments since the October 2000 report; and
- Options for the future.

Goals and Objectives

The goal of this report is to provide information needed to plan and forecast the needs and interventions for long-term care consumers in the area of Non-Medical Home and Community Based Services (NMHCBS) and the Arizona Long Term Care System (ALTCS) Home and Community Based Services (HCBS) programs. The objectives in creating this report are to:

- Provide administrative and demographic data;
- Identify implications based on the data;
- Identify areas for outreach, education, and prevention; and
- Share data and implications with other interested parties planning for growth.

Background

"If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability and many other needs that such growth brings."[1]

As persons with disabilities and the aging population grow in Arizona, the demand for NMHCBS and ALTCS will increase. According to the Arizona Department of Economic Security, Research Administration, Population Statistics Unit, some of the demographic realities facing Arizona now and in the future are:

- In 2000, there were approximately 5.1 million people living in Arizona;
- This is anticipated to increase to 9.8 million people by 2040;
- The number of persons 55 or older will increase from about 1 million in 1997 to more than 2.2 million by 2020;
- By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the population over 64 years old;

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[1] 72nd Arizona Town Hall and University of Arizona (1998). "Meeting the Challenges and Opportunities of Arizona' s Growing Senior Population,"pp. 1-3, Tucson, Arizona.

Background Continued

- Currently 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care;
- The income of elderly women is falling progressively farther behind that of their male counterparts. This disparity in income affects both the NMHCBS and ALTCS programs, since the primary consumer is female. In 1989, the median income for a single male 65 years of age or older was $13,107 versus single women at $7,655[2]. In 2000, the median income for a single male 65 years of age or older was $19,168 versus single women at $10,899.[3]
- The number of Arizonans age 65 and older has increased by 39.5% from 1990 to 2000 compared to a 12.4% increase nationally.
- Arizona Native Americans account for 17% of the Native American population in the United States aged 65 or older;[4] and
- The AHCCCS budget for long term care is approximately 34% of the total AHCCCS budget for 6% of the enrolled population.

The elderly and physically disabled (EPD) community is making strides with "consumer directed care" or "person centered planning." Older consumers have reported significant satisfaction with directing their own care and having control over services, schedules, and workers. In particular, many older participants want to hire family members as their workers. From a public policy perspective, the use of family members also helps address current shortages of personal care workers.[5] This also eases the financial burden on caregivers that have stopped working in order to care for a family member. This demand for inclusion in the decision-making process is further supported by the numerous articles that articulate the fact that the "baby boomers" will want more involvement regarding their current and future needs.[6]

HCBS programs show an overall sustained growth. With the growth, comes an increase in expenditures.

- NMHCBS had a 12% overall growth in the last four years (1998 - 2001).
- The total ALTCS/EPD population had an overall growth of 16% from 1999 to 2001. Of that population, the HCBS population grew 30% since 1999.
- NMHCBS expenditures have grown by 9%.
- ALTCS/HCBS expenditures have increased by 37% from FFY 1999 to FFY 2001.

By increasing the percentage of persons living in the community, AHCCCS has kept overall costs lower than the costs would have been if the same population were in a nursing facility.

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2 A Profile of Older Americans 2001 - U.S. Department of Health and Human Services, Administration on Aging
3 A Profile of Older Americans 2001 - U.S. Department of Health and Human Services, Administration on Aging
4 72nd Arizona Town Hall and University of Arizona (1998). Arizona Department of Economic Security Projects, Tucson, Arizona.
5 AARP Public Policy Institute (November, 2001). "Consumer-Directed Services for Older People," p. 13, Washington, DC.
6 Accountability Action – Volume 4: Issues 1 and 2 (fall, 1999 / winter, 2000). "The Need is Real, the Time is Right," published by the Foundation for Accountability, Portland, Oregon.

Report Summary, Continued

About the Report

The report is divided into six chapters:

- Whom Do We Serve?
- What Are The Trends In Enrollment?
- What Funding Sources Are Used For HCBS Programs?
- How Is The Money Spent?
- What Have We Accomplished?
- Where Do We Go From Here?

The report is primarily limited to information about Arizona's NMHCBS program and the ALTCS Program for 2001. Other limitations include:

- NMHCBS utilizes the state fiscal year (SFY) calendar for annual reporting (7/1-6/30);
- ALTCS utilizes the federal fiscal year (FFY) calendar for annual reporting (10/1-9/30); and
- NMHCBS and ALTCS use similar data collection methodologies, but parameters may differ (e.g. age ranges).

The focus of the report is the Arizona aging population with an emphasis on the elderly and physically disabled (EPD) ALTCS and NMHCBS populations. For more information, including national comparisons, the reader may wish to review the 1998 and 2000 Community Based Services and Settings Reports presented by the community based project task force located on the Internet at http://www.ahcccs.state.az.us/Publications/reports.htm.

Policy Issues

Now is the time to increase our understanding of the economic trends and their intersection with demographics. Future growth and increased demands on the current structure require creative and innovative strategies from the community, for-profit, non-profit and governmental agencies. Some findings that will have an impact on Arizona's policy issues are highlighted below:

- Shifting attitudes about the roles and responsibilities of paraprofessional providers of care;
- Aging population will reach 2.2 million people in Arizona by 2020;
- Changes in the roles of the informal family support system;
- Consumers want a comprehensive approach to long term care;
- Arizona baby boomers lack education regarding long term care issues and resources and are not prepared for the future;
- Seniors lack education regarding healthy aging;
- Cost and mandates of NMHCBS;
- Consumers want access, availability, and increased delivery of quality NMHCBS and ALTCS HCBS; and
- A critical shortage of a sufficient labor force to address the demand for services.

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Conclusion

Nationally, President Bush and a collaborative team of federal agencies have expressed their commitment to expand access to home and community-based services for persons of all ages with disabilities. The President stated in Executive Order 13217, "The United States is committed to community-based alternatives for individuals with disabilities and recognizes that such services advance the best interests of Americans."[7]

Arizona policy makers and agency heads have identified the need to share data and work collaboratively to forecast and plan LTC HCBS services. AHCCCS, DES and ADHS have formed the "Tri-Agency Committee" in a collaborative effort to research, review and implement innovative strategies to address long term care issues. These include preventive strategies like educating Arizonans about healthy aging. The goal of sharing data and its implications has been accomplished by producing this report. The next steps for Arizona call for maintaining momentum by continuing to:

- Share data;
- Identify gaps, forecast and plan for the future needs of long term care accordingly;
- Collaborate on key policy implications (e.g., additional needs and service gaps);
- Identify needs and opportunities for outreach and education;
- Identify opportunities for preventive measures to maintain a healthier population; and
- Monitor the progress of the efforts.

ADES, ADHS and AHCCCS are committed to maintaining a range of services and supports for aging Arizonans that will provide the population with choices and maintain independence and dignity, while also addressing the needs of their caregivers. As a new partner, ADHS promotes growth and safety in the assisted living settings through its licensure and oversight functions, and facilitates health promotion and maintenance of quality of life through its Healthy Aging 2010 project.

7 Executive Order 13217 dated June 18, 2001.

Chapter 1: Whom Do We Serve?

Introduction

Currently, there are at least 281 million people living in the United States.[8] In 2000, there were approximately 5.1 million people living in Arizona.[9] This is anticipated to increase to 9.8 million people in Arizona by 2040.[10]

"In Arizona, the Department of Economic Security projects that the number of citizens 55 or older will increase from about 1 million in 1997 to more than 2.2 million by 2020. By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the age 65 or older population. Arizona Native Americans account for 17% of the Native American population 65 years of age or older in the United States.[11] Currently, 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care.[12]

Fast Facts

NMHCBS and ALTCS populations are similar in terms of gender and ethnicity. For gender, both programs serve mainly women, 69% and 66% respectively. The primary consumer in the NMHCBS program is a white female between the ages of 75 and 89. In the ALTCS program, the primary customer is a white female between the ages of 80 and 84. They also serve similar ethnic populations. (See page 9)

The two programs have key differences in the ages of people they serve. ALTCS serves a larger percentage of younger individuals as well as a larger percentage of very old individuals as compared to NMHCBS. The following statistics support this conclusion.

Program	Age Group	Percentage
ALTCS (EPD Only)	0 to 64*	27%
	90 and older	16%
NMHCBS	0 to 60**	11%
	90 and older	9%

* ALTCS Physically disabled (non-DD) children aged 0 to 21 have grown steadily since 1993. Examples of the disabilities within the program are: ventilator dependent; muscular disorders; spina bifida; and behavioral health disorders organic in nature.

** By design, the NMHCBS program serves persons under 60 with a documented disability.

A typical in-home consumer is a white female in her 80s who needs assistance with activity of daily living (ADL) deficits such as bathing and instrumental activity of daily living (IADL) deficits such as shopping, laundry, and housekeeping. Deficits are due to the aging and disease processes. Anecdotally, the NMHCBS program may keep consumers from entering into the ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance.

Usually those consumers in the ALTCS program have more functional and medical needs. There are however, consumers in the NMHCBS program who are very frail but do not qualify for ALTCS because of too much income.

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[8] AARP, (1998). Across the States 1998; Profiles of Long-Term Care Systems, pg. 5, Washington, D.C.
[9] AZ Department of Economic Security, Research Administration, Population Statistics Unit (2000 census), Phoenix, AZ
[10] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ
[11] 72nd Arizona Town Hall and University of Arizona (1998). "The Challenges and Opportunities of Arizona' s Growing Senior Population,"pp. 1-3, Tucson, Arizona
[12] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

Implications

With the growth of the Arizona population, both programs can expect steady increases in the aging and disabled populations.

This increased growth in the aging and disabled populations will mean a demand for more services compounded by the fact that there is an increasing number of family caregivers in the workforce who have traditionally stayed at home. "The most typical employed family caregiver, according to the U. S. Department of Labor, is a woman in her mid-forties who is employed and provides, on average 18 hours of care per week for her mother who either lives with her or nearby."[13] "According to a survey by the National Family Caregivers Association in Kensington, Maryland, 61% of those who have been family caregivers for an extended period of time report feeling depressed, and 67% report being frustrated."[14] "Caregivers experience depression at three times the rate of others in their age group due to the emotional demands of caring for a family member" and "One-third of all caregivers describe their own health as fair to poor."[15] Three issues may then occur:

- The working caregivers need respite and request it from the HCBS programs (see growth in the respite program in the enrollment chapter);
- The consumer may need more care than can be provided by the caregiver and requests it from the HCBS programs; and/or
- The competing demands of family caregiving and employment may place the family caregiver's health at risk such that it impacts both employment and caregiving.

Comparison of Aging Trends AZ vs. US

The following charts demonstrate the national and state trends for the aging population.

65+ Population in Arizona 2000 Compared to U.S. Total (1990 & 2000 Census)

	Number of Persons	Percent of All Ages	Percent of Increase 1990-2000	Percent Below Poverty 1998-2000
U.S. Total	34,991,753	12.4%	12.0%	10.1%
Arizona	667,839	13.0%	39.5%	8.8%

Population in Arizona by 60+ Age Groups Compared to U.S. Total (Census 2000)

	60-64	65-69	70-74	75-79	80-84	85+
U.S.	10,805,447	9,533,545	8,857,441	7,415,813	4,945,367	4,239,587
AZ	203,697	189,007	174,834	144,201	91,272	68,525

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[13] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.
[14] Gauzer, Bernard (July, 2000). "How Can We Help," p. 4 and 5, Parade, Arizona Daily Star, New York, New York.
[15] Agency On Aging (May 2001). Family Caregiving Fact Sheet

Comparison of Aging Trends AZ vs. US continued

Percent Distribution of Population and Rank by Age Group (Census 2000)

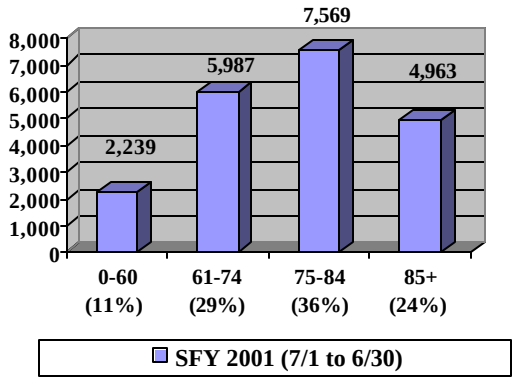
	60+		65+		75+		85+	
U.S. Total	16.3%		12.4%		5.9%		1.5%	
Arizona	17.0%	21	13.0%	22	5.9%	26	1.3%	38

Age

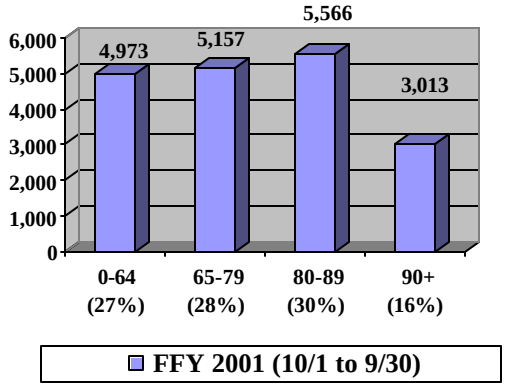
The following charts show the differences and similarities between age cohorts, for both gender and ethnicity in NMHCBS and ALTCS.

NOTE: *The enrollment numbers for the NMHCBS program are cumulative for the year. The ALTCS numbers are not cumulative, but represent the total current enrollment at the end of the fiscal year.*

NMHCBS



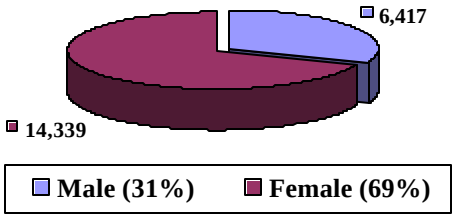
ALTCS (Nursing Facilities and HCBS)



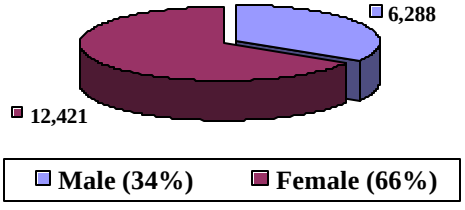
Gender

Both programs serve primarily women (69% NMHCBS and 66% ALTCS). ALTCS served 51% of its population in the community in FFY 2001.

NMHCBS (population: 20,756)



ALTCS (EPD population: 18,709)
(HCBS and Nursing Facility)



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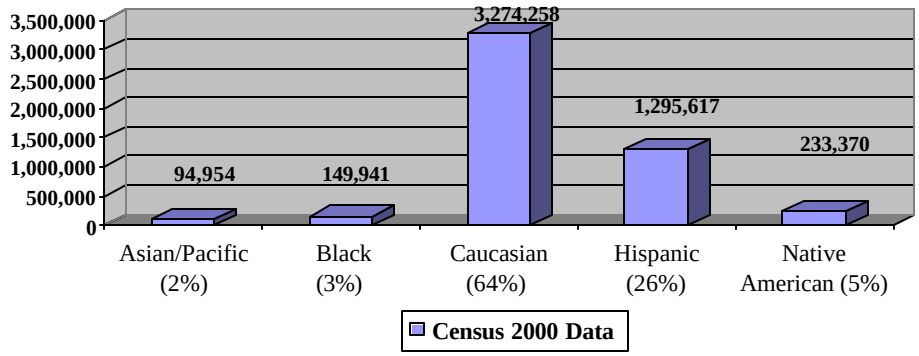
Ethnicity of Arizona's General Population

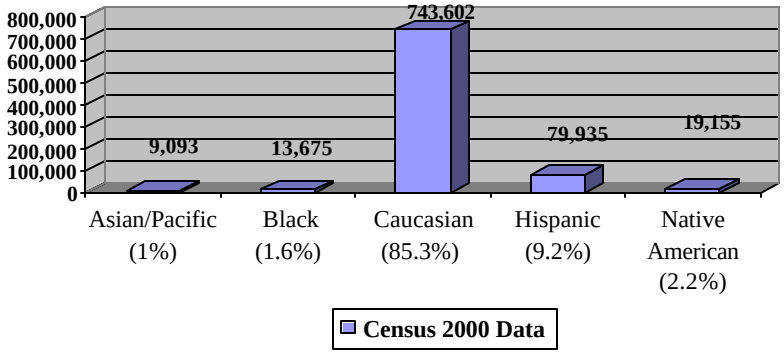
A graph of the general population for Arizona has been included to compare the ethnicity of the general population to those in both programs.



Source: *Population Estimates Program, Population Division, U.S. Census Bureau.*

Ethnicity of Arizona's Aging Population

Arizona residents aged 60+ by race based on Census 2000 information.



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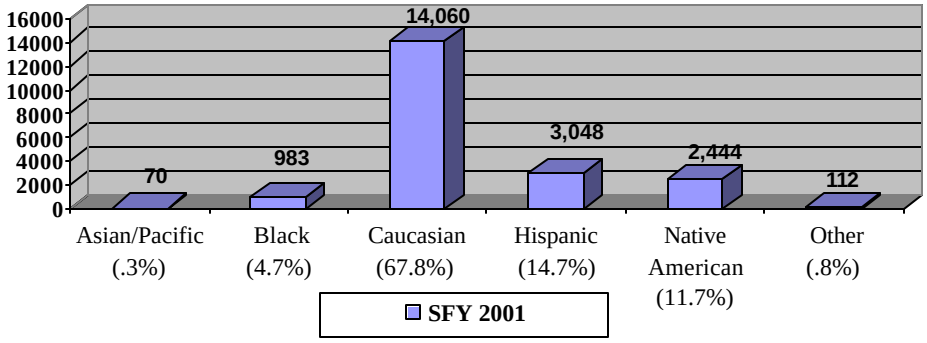
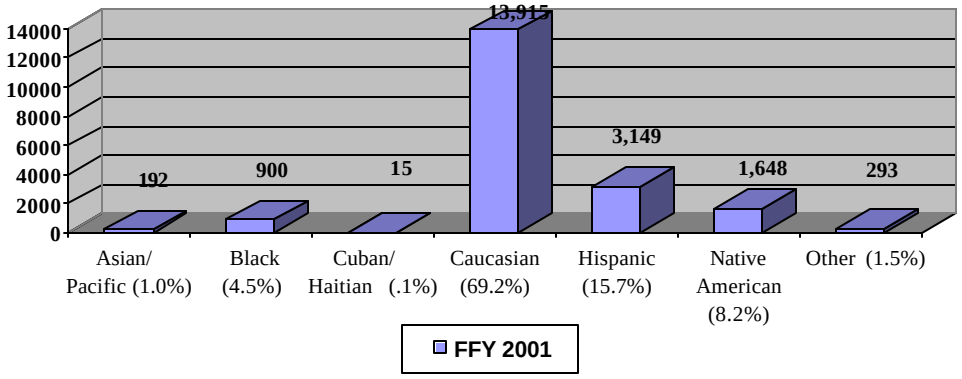
Ethnicity

Both programs serve similar ethnic populations.

NMHCBS



ALTCS EPD and Native Americans (Nursing Facilities and HCBS)



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Chapter 2: What Are The Trends In Enrollment?

Introduction

"If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability, and many other needs that such growth brings."[16] Demographics coupled with the following information, when trended over time, may assist policy makers and stakeholders with future strategies in servicing this growing population.

Fast Facts

ADHS Assurance & Licensure Services reports that capacity in alternative residential settings is as follows:

- 1,077 assisted living homes,
- 252 adult foster care homes,
- 186 assisted living centers, and
- 23,800 beds in the assisted living homes and centers.

(See Attachment A for definitions)

NMHCBS has seen an increase in demand for services. NMHCBS enrollment has grown 10% since 1997 (18,570 to 20,462). The following service needs in NMHCBS changed from 1997 to 2001 (see Attachment C and page 22 for more details):

- Respite has increased during this timeframe by 11%.
- The NMHCBS program shifted many consumers to personal care service from home health aid based on newly developed criteria. This enabled the program to serve more consumers.
- The NMHCBS program operates on a fixed cost basis, not an entitlement. As a result, the program has been unable to fully meet demands of those requesting and qualifying for services. There was a statewide waiting list of approximately 629 consumers as of June 30, 2001.

ALTCS The number of EPD in ALTCS has grown from 35% to 51% since 1996. Overall program growth for the last five years was 46% (12,788 to 18,709).

- Nursing home enrollment has decreased by 3% of the total population since 1999 (1999=50% to 2001=47%); and
- With the advent of increased choice in settings, the number and percent of ALTCS members choosing alternative residential settings has increased significantly.
- From January 1999 to January 2002, the proportion of members living in alternative residential settings has increased by 8%, and the proportion of members living in their own homes has increased by 4%.

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[16] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

Implications

- Continued growth in both programs means continued and increasing demands on a strained professional and paraprofessional work force.
- Innovative strategies are needed to continue to keep consumers in their own homes.
- Nationally, there is a concerted effort by the disability community for input in their care. Numerous articles also articulate the notion that the "baby boomers" will also want more involvement regarding how their current and future needs are met.[17]
- Alternative residential settings must continue to expand. Consumers who cannot live in their homes, but are not ready for a nursing facility, need alternative choices.
- Consumers will continue to need assistance with coordination of care/services via some type of case management or care coordination (case management is described in Appendix B).

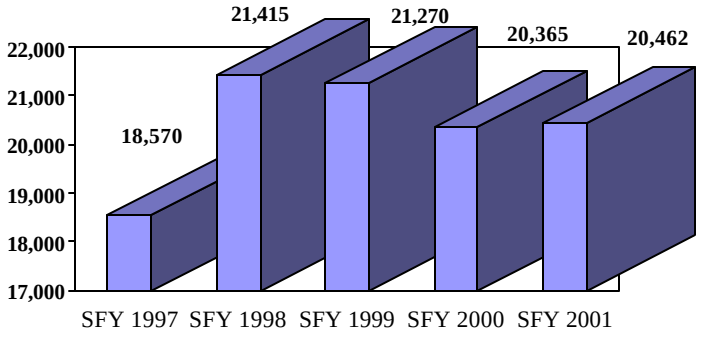
NMHCBS

The NMHCBS program has grown by approximately 10% (18,570 to 20,462) in the last five years. However, the program did see a 1% decline in enrollment from 1998 to 1999. This slight decrease was attributable to:

- Increased adherence by case managers to the functional eligibility criteria;
- Fixed revenues, meaning no additional funds were available to accommodate demand.

Services

NMHCBS offers seven in-home services: adult day care/adult day health care (ADHC); home delivered meals (HDM); home health aid (HHA); home nursing (HRN); housekeeping (HSK); personal care (PC); and respite care (RC). The graphs below illustrate the total number of unduplicated (counted only once) clients. Consumers may receive several services at one time (e.g., personal care, meals, and housekeeping). Decreases in enrollment reflect a combination of factors. An increase in contracted rates, demand for higher levels of service by existing clients, and a lack of funds for specific settings restrict the NMHCBS program from allowing more enrollees to access the services. Thus the enrollees are placed on a waiting list.



Note: *This includes individuals receiving Adult Day Care/Adult Day Health Care, Home Delivered Meals, Home Health Aid, Housekeeping, Personal Care, Respite Care, Home Nursing, and Case Management.*

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[17] Accountability Action – Volume 4: Issues 1 and 2 (fall 1999 / winter 2000). "The Need is Real, The Time is Right," published by the Foundation for Accountability, Portland Oregon.

Chapter 2: What Are The Trends In Enrollment?, Continued

Enrollment Growth

The table below illustrates the percentage of growth in enrollment from SFY 1997 to SFY 2001.

NMHCBS Service	% of Growth SFY 1997 to 2001	Explanation
Home Health Aid	-71% (Decrease)	Establishment of medical needs criteria for service; if it is purely functional, the consumer is given a personal care service.
Home Nursing	-26% (Decrease)	Establishment of medical need criteria for service.
Adult DayCare/Adult Day Health Care	11% (Increase	Several Area Agencies on Aging allocated new funds received for the Family Caregiver Support Program to existing programs in order to expand respite services for caregivers.
Housekeeping	-4% (Decrease)	Decrease in consumers requiring only housekeeping services. Transfer of some consumers to personal care services, and a decrease in the number of consumers receiving the housekeeping direct pay.
Home Delivered Meals	22% (Increase)	The program received an increase in federal funds.
Personal Care	25% (Increase)	Consumers began using personal care service rather than home health aid if the assistance needs were functional in nature only and had no medical component.
Respite Care	7% (Increase)	The program received a federal grant for caregivers for respite care.

NMHCBS Services SFY2001

The table below illustrates the number of persons utilizing NMHCBS by service and by county.

N M H C B S (OWN HOME)

COUNTIES	HHA	PC	HOME NURSING	HSK	RESPITE	HDM	ADHC	Unduplicated Count
Apache	0	0	37	61	86	2295	0	2448
Cochise	4	339	53	774	43	487	78	1314
Coconino	37	0	51	179	25	356	0	547
Gila	5	0	6	0	17	272	0	435
Graham	0	44	36	102	5	118	0	209
Greenlee	0	38	0	45	0	104	67	162
LaPaz	0	14	0	77	3	107	0	174
Maricopa	334	686	147	2907	116	3263	193	6411
Mohave	0	102	37	366	40	966	0	1350
Navajo	35	32	85	180	27	407	0	599
Pima	3	457	109	1386	99	1573	120	3776
Pinal	26	0	115	0	10	426	0	1162
Santa Cruz	68	13	88	109	5	102	0	279
Yavapai	0	145	301	189	8	1189	15	1442
Yuma	61	49	16	279	24	310	19	869
Totals	**583**	**1,919**	**1,126**	**6,708**	**508**	**11,921**	**347**	**20,462**

Key: HHA =Home Health Aid, PC = Personal Care, HSK = Housekeeping, HDM = Home Delivered Meals, ADHC = Adult Day Health Care.

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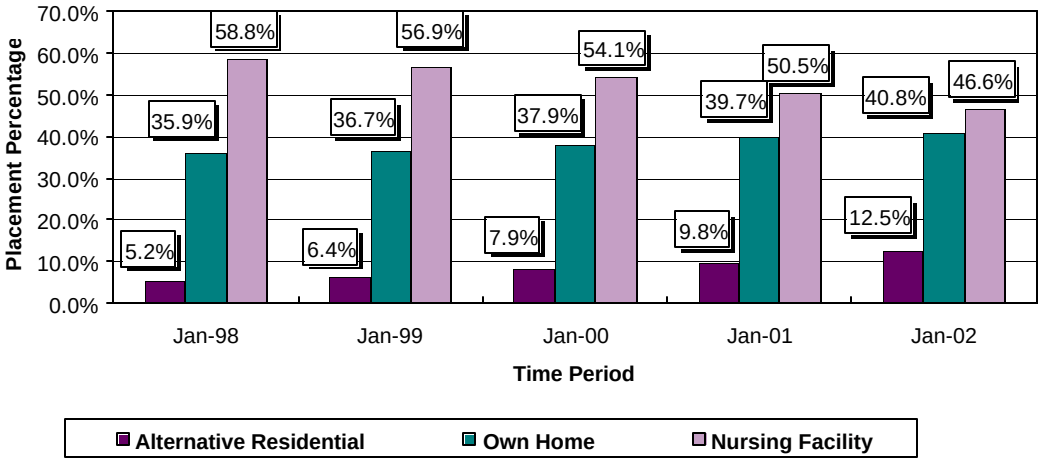
ALTCS / HCBS

ALTCS/EPD services are provided to persons who are elderly or who have a physical disability by program contractors under contract with AHCCCS in the fifteen Arizona counties. Program contractors coordinate, manage and provide acute care, institutional care, home and community based care, behavioral health services, and case management services to ALTCS/EPD consumers. The typical ALTCS/EPD consumer is a white female between 80 and 89 years of age, and 16% of the EPD consumers are over 90 years of age.

ALTCS does not have enrollment figures by specific in-home services. The ALTCS HCBS program offers consumers the choice of living in their own home or in an alternative community setting. The community alternative settings are:

- Adult foster care (AFC);
- Assisted Living Center - Units;
- Assisted Living Home; or
- Behavioral health (BH) setting.

The following graph shows the distribution of members between alternative residential setting, own home, and nursing facility. The percentage of members residing in alternative residential settings more than doubled from 5.2% in 1998 to 12.5% as of January 2002. The proportion of members residing in their own homes has continued to increase while the percentage of members residing in a nursing facility has declined from 58.8% in 1998 to 46.6% as of January 2002. The other two settings show corresponding increases for every time period reported.



Note: January 2002 percentages were included to reflect the population for FFY 2001 which began October 1, 2000 and endedOctober 1, 2001.

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Alternatives

As a percentage of alternative residential settings, the following enrollment trends apply:

- AFCs have decreased since 1999 from 47% to 24% in 2001;
- Assisted living centers have increased from 24% in 1999 to 36% in 2001;
- Assisted living homes have increased from 23% in 1999 to 35% in 2001; and
- Behavioral health settings have decreased from 6% in 1999 to 5% in 2001.

Note: *See Appendix A for definitions.*

ALTCS In Home Services & Settings

The chart below illustrates the number of persons receiving services in their own home or in alternative settings in the community by service/setting and county in FFY 2001. The distribution of members in alternative settings is shown in the center section of the chart. Adult foster care (four or less persons) has shown a decline in the number and proportion of people residing in this setting. Adult foster care was the only alternative residential setting available for the EPD members when the program originally began in 1989. Assisted living centers and assisted living homes became available for ALTCS members approximately 6 years into the program. Because of the availability and growth in the use of these settings, adult foster care placements have declined. However, as previously noted there has been continuous growth in alternative residential placements as a whole.

County	FFY01 Home and Community-Based Services (HCBS)						
		Alternative Residential					
	*Own Home	AFC	ALC	Behavioral Hlth.	ALH	Total Alt. Res.	Total
Apache	56				10	10	66
Cochise	349			1	8	9	358
Coconino	80		11	1	3	15	95
Gila	58		3		3	6	64
Graham	53				2	2	55
Greenlee	5					0	5
La Paz	36		3			3	39
Maricopa	4,033	378	514	69	385	1,346	5,379
Mohave	226	23	62		19	104	330
Navajo	131		4		30	34	165
Pima	1,183	95	130	26	206	457	1,640
Pinal	352	5	13	7	27	52	404
Santa Cruz	125			3	7	10	135
Yavapai	452	14	45		16	75	527
Yuma	180		11		39	50	230
Totals	**7,319**	**515**	**796**	**107**	**755**	**2,173**	**9,492**

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Counties: 9,492
Total Alternative Residential: 2,173 (23%)

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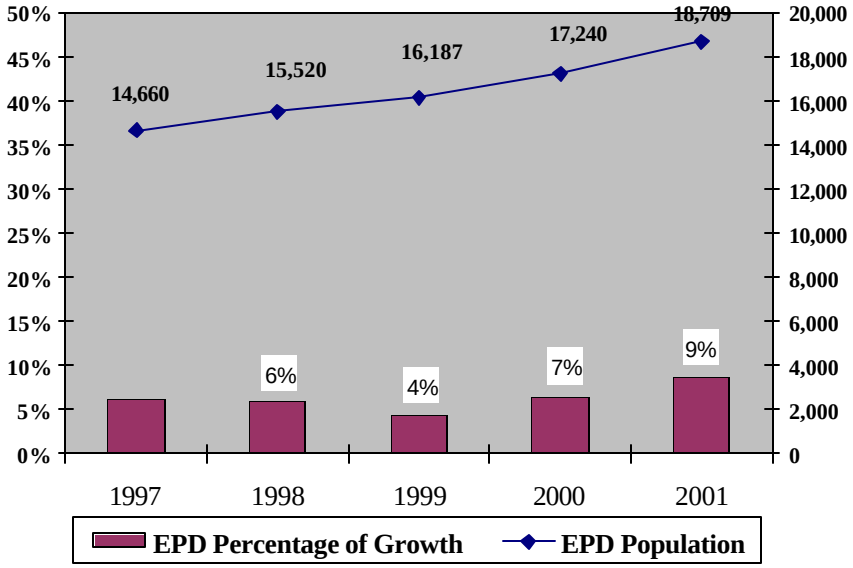
ALTCS / EPD Enrollment

The following graph includes statistics on Elderly and Physically Disabled enrollments from October 1997 - 2001.



Note: Excludes "On Reservation " Native Americans.

ALTCS / HCBS Native American EPD Enrollment

The ALTCS Native American population resides either "On Reservation" or "Off Reservation." Most "off reservation" Native Americans (urban) are enrolled with the program contractor who provides services for that county. "On Reservation" Native Americans are either case managed by their tribe or by the *Native American Community Health Center (NACHC). There has been a steady increase in both total ALTCS population and in the number of consumers in HCBS. The increase in HCBS is attributable to the efforts of both the Inter-Tribal Council of Arizona (ITCA) and the Navajo Nation.

ITCA received a five-year grant in 1998 to target and assist tribes in their efforts to build HCBS networks. They have also been diligent in developing outreach programs for the ALTCS program. The Navajo Nation has made strides in developing an independent provider network as well as collaboratively working with their service units to increase workers for the ALTCS HCBS consumers who live on reservation. The chart on the next page shows statistics on ALTCS Native American population growth. There has been a 68% increase in population during the last four years and 79% growth in HCBS during the last four years. Currently 55% of the “On Reservation” Native Americans live in the community.

*Native American Community Health Center (NACHC) represents all other tribes not contracted with AHCCCS

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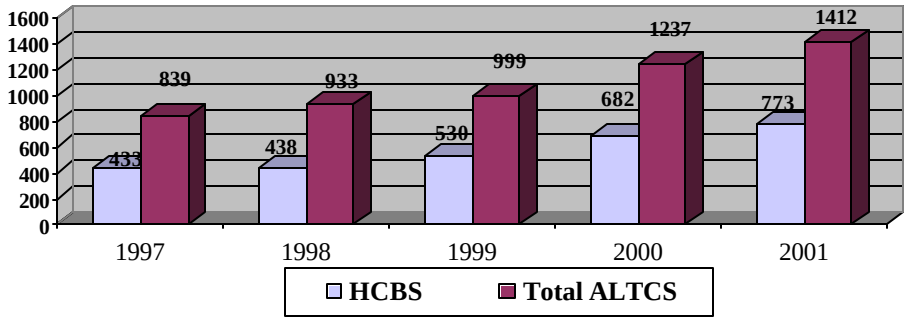
ALTCS Native American EPD Enrollment



ALTCS In-Home Services / Settings-Native American

The chart below illustrates the number of persons receiving services in their own home or in alternative residential settings in the community by tribe and services/settings in FFY2001.

**Note: There is not the availability of alternative settings on or near reservations as there is "off reservation" statewide.*

Tribe	Home and Community-Based Services (HCBS)					
	*Own Home	AFC	ALC	Behavioral Hlth.	ALH	Total HCBS
Gila River	23	-	-	-	-	23
NACHC*	111	-	-	-	1	112
Navajo	434	-	-	-	1	435
Pascua Yaqui	19	-	-	-	-	19
San Carlos	32	-	-	-	-	32
Tohono O' Odham	93	-	-	-	-	93
White Mountain	59	-	-	-	-	59
Totals	**771**	-	-	-	**2**	**773**

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Tribes: 773
Total Alternative Residential: 2

Chapter 3: What Funding Sources Are Used For HCBS Programs?

Introduction

As the individuals with disabilities and the aging populations grow in Arizona, the demand for DES Non-Medical Home and Community Based Services (NMHCBS) and ALTCS medically necessary long-term care (LTC) services (nursing facility and HCBS) will increase. These services are primarily funded by Medicaid (Title XIX), through the Arizona Health Care Cost Containment System (AHCCCS), and state services through the Arizona Department of Economic Security (ADES) (Older Americans Act, Title III/Social Services Block Grant, Title XX, and community funds). To further clarify the funding for both programs, more detailed information is provided in this chapter.

Fast Facts

- The majority of NMHCBS program dollars for home care (RN, HHA, PC, HSK, and ADHC) is from state appropriations (74%). This is *not* an entitlement program, but an appropriation. The state appropriation has remained at $8 million annually since 1994.
- The majority of ALTCS program dollars are from federal appropriations (66%).

Implications

The NMHCBS program is not an entitlement program. Services are limited by the authorized level of funding. The wating list for services in June 2001 was 629 consumers. The waiting list does not fully reflect the need in the community. Potential consumers may become discouraged and may choose not to apply or may decide to be removed from the waiting list.

The ALTCS program is an entitlement based on financial, functional and medical criteria. As an entitlement program, ALTCS has a better financial ability to meet consumer needs.

The increase in the future population over age 65 and the fact that they may not have enough money to take care of their needs may require additional funding to maintain consumers at a maximum level of independence.

Continued on next page

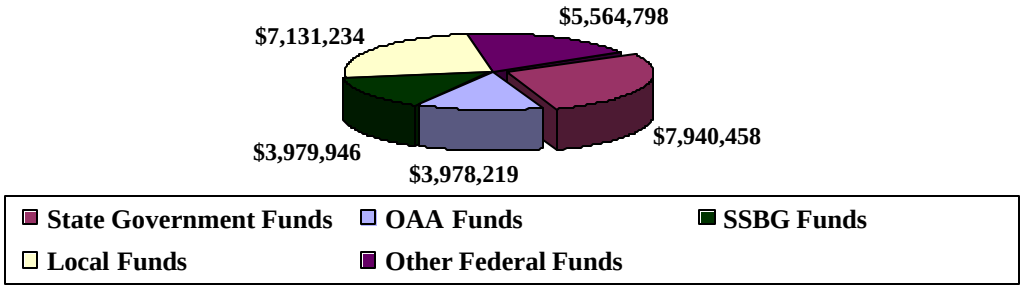
NMHCBS

Federal, state, and local funding are combined to support the NMHCBS System. The funding sources include the following:

- Federal Funds:
  - Older Americans Act, Amendments of 2000, (PL 106-501) (OAA, Title III and Title VII),and
  - Social Services Block Grant (SSBG);
- State Appropriated Funds; and
- Locally generated sources including client contributions, city funds, county funds, United Way funds, and local foundations.

The total service funds for NMHCBS for SFY 2001 which were expended, totaled $28,594,655. The breakout is indicated below.

- Home Care funding includes HRN, HHA, PC, HSK, ADHC, Respite and CM. Total funding for this area was 28% state, 25% local funds, and 47% federal funds. The federal funding percentages are; OAA funds - 14%, SSBG funds - 14%, and other federal funds - 19%.
- Home Delivered Meals are primarily federally funded (OAA, USDA, SSBG). County, community, and consumer contributions are allocated to the home care and meals programs. These additional funds enable more people to be served.



Total Funds for SFY 2001: $28,594,655

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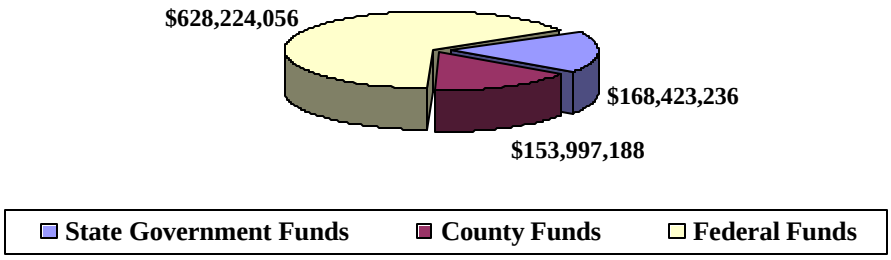
Chapter 3: What Funding Sources Are Used For HCBS Programs?, Continued

ALTCS / HCBS

The ALTCS program (EPD and DD) is funded by three sources:

- Federal funds / Medicaid (Title XIX) = 66%,
- County funds = 16%, and
- State funds = 18%.

ALTCS Sources of Funds for FFY 2001:



Total Funds for FFY 2001: $950,644,480

Services include medical, behavioral, nursing facility and HCBS. The total ALTCS funds for FFY 2001were $950,644,480 (includes Title XIX DDD population). The ALTCS budget is approximately 34% of the entire AHCCCS budget. 57% of the ALTCS population are Elderly or Physically Disabled (EPD). Of those, 51% reside in the community.

Note: *EPD only budget is approximately $560 million.*

Chapter 4: How Is The Money Spent?

Introduction

In 2000, the median income in Arizona for a single male 65 years of age or older was $19,168 versus single women who were at $10,899. FY 2001 data is unavailable. This implies that, for a fair share of our population, the ability to purchase needed services privately will be limited.

- Nationally, less than one-half of those over 65 have set aside an adequate amount of money to take them all the way through retirement.[18]
- A baby boomer focus group conducted by the Arizona Long Term Care Project has demonstrated that Arizona baby boomers are no more prepared than the national trends cited.
- "Nationally, younger boomers (32 to 40 years old) have experienced significant declines in their real income levels. Close to 15% of all baby boomers lack a high school diploma."[19]

As the baby boomer generation continues to age, there is increasingly more demand for HCBS services. Chapter 4 will describe how the money is spent and on what type of services. It will also demonstrate that HCBS services and settings, in the ALTCS program, are cost efficient and respond to consumer choice.

Fast Facts

NMHCBS expenditures are reported by State Fiscal Year (7/1 to 6/30). Expenditures have grown 21% from 1997 to 2001. The biggest increases are in personal care and respite care, which correlates with the shift from home health aid to personal care and the increase in demand and funding for respite care. Nationally, "respite care is the most prevalent service provided by states for family caregivers."[20]

ALTCS HCBS expenditures have grown by 27% from 2000 to 2001.

- The biggest increase is in the "Attendant Care" category, which is the key factor in the increase. Many consumers can better direct their care by having an attendant versus separate staff entering their home for various tasks. This fact makes this service a high demand service.
- Since FFY 1998, the EPD population has continued to grow from 4% to 9% annually with an overall growth of 28% in the last 5 years. During the same timeframe, the HCBS percentage of the total ALTCS population has gone from 35% to 51%. This represents a 46% growth in HCBS. The growth in capitation has remained almost constant from 1997 to 2001 because consumers are requesting in-home services and it is more cost effective to maintain consumers in their own home or alternative setting. Trends indicate the number of people living in the community will continue to increase.

Continued on next page

[18] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.
[19] Aging Initiative: Project 2030 (January, 1999). "Workforce and Economic Vitality Issue Paper," p. 6, St. Paul, Minnesota.
[20] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.

Fast Facts, Continued

The ALTCS Program as a whole somewhat mirrors the national trend for Medicaid.

- "Nationally, in 1993, poor elderly and non-elderly disabled represented 27% of the total Medicaid enrollees, but consumed 59% of all Medicaid dollars. Impoverished adults and children, on the other hand, represented 73% of enrollees, but consumed only 27% of all Medicaid dollars."[21]
- The EPD population uses 60% of the entire ALTCS budget and represents 57% of the ALTCS population. Of those, 51% resided in the community in FFY 2001.
- "The most significant is the fact that the baby bust generation (the generation following the baby boomers) constitutes a much smaller proportion of the population than the baby boomers. As a result, there will be fewer working age adults to support the needs of a large elderly population through their economic productivity and tax revenues."[22]

Implications

As the long-term care programs become a greater portion of our government' s budget, the state needs to understand the following:

- Baby boomers may request changes in the current service package that may or may not impact expenditures.
- Both programs have implemented and continue to research strategies for hiring paraprofessionals to meet the consumer demand (see Chapter 5, "What Have We Accomplished"). This is especially important in the recruitment of attendant care providers.
- As the need for health and long-term care is growing, our resources will be increasingly stretched.
- Emphasis needs to be placed on education and prevention at an earlier age to increase the general health of the older population.

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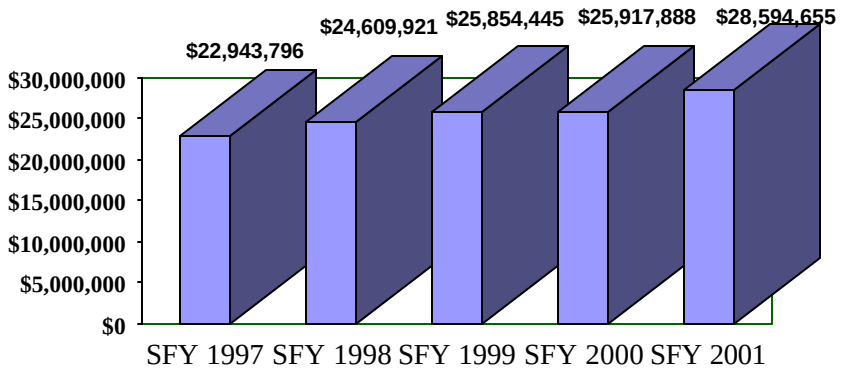
[21] The Robert Wood Johnson Foundation (August, 1996). "Chronic Care in America: A 21st Century Challenge," p. 46, Princeton, New Jersey.
[22] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.

NMHCBS

NMHCBS has seen an increase in cost from approximately $23 million in SFY 1997 to $28 million in SFY 2001. Non-medical HCBS expenditures are reported on a state fiscal year (July 1 to June 30) schedule. Total expenditures for SFY 2001 are $28,594,655. This includes federal, state, county, and community contributions.

The graph below shows the totals for all of the non-medical expenditures. Figures include case management with a range from $3.5 million to $4.4 million from SFY 1997 to SFY 2001.



The table below demonstrates the total increase and decrease in expenditures by service from 1997 to 2001. The chart on the following page shows increases and decreases by year.

Increases in the expenditures for home delivered meals and adult day care/adult day health care is due to increases in the federal funding that is received by the Area Agencies on Aging. The establishment of medical needs criteria for home health aid and home nursing resulted in decreases in the expenditures for home health aid and home nursing and increases in the expenditures for personal care and housekeeping. The increase in expenditures for respite services reflects more demand for respite services and the increased need for respite services by the community.

Service	% of Growth: SFY 1997 to SFY 2001
Adult Day Health	27% (Increase)
Home Health Aid	-57%% (Decrease)
Home Nursing	-3% (Decrease)
Home Delivered Meals	20% (Increase)
Respite Care	84% (Increase)
Personal Care	50% (Increase)
Housekeeping	27% (Increase)

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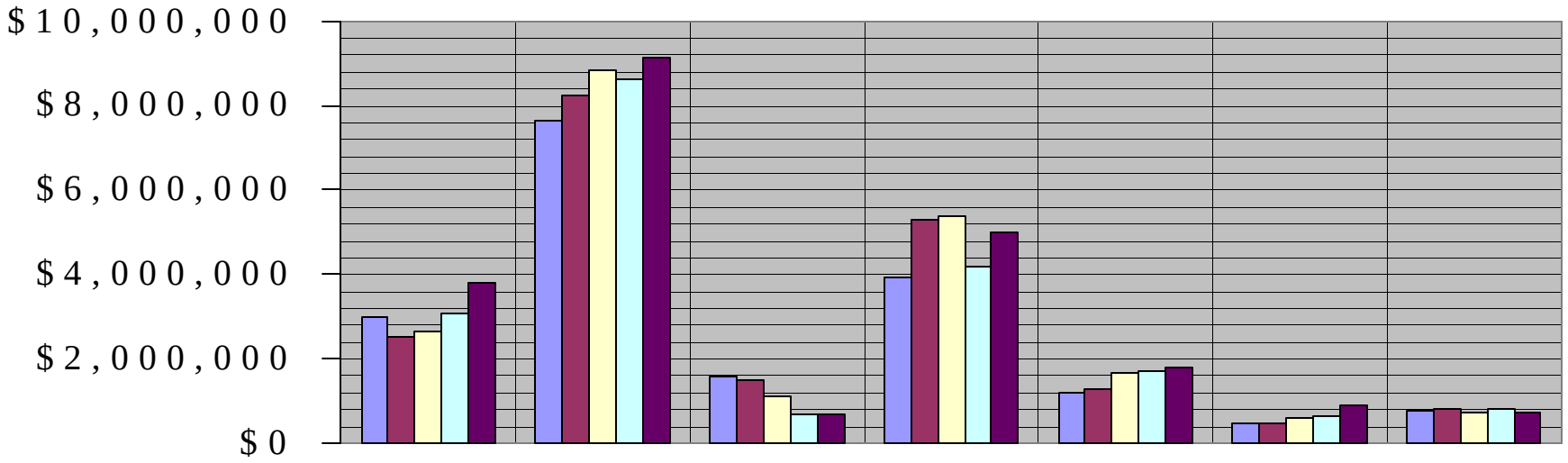
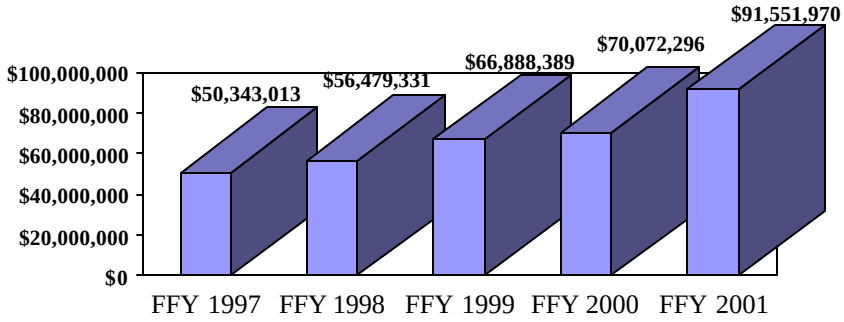
NON-MEDICAL HOME AND COMMUNITY BASED SERVICES (NMHCBS): EXPENDITURES* (STATE & FEDERAL FUNDS)



	Adult Day Health	Home Delivered Meals	Home Health Aide	House-keeping	Personal Care	Respite Care	Home Nursing
1997	$3,004,569	$7,627,404	$1,558,474	$3,936,874	$1,200,002	$477,736	$763,238
1998	$2,529,550	$8,254,681	$1,510,502	$5,277,400	$1,267,814	$479,268	$806,051
1999	$2,626,412	$8,849,598	$1,106,902	$5,376,389	$1,685,448	$620,857	$746,744
2000	$3,079,051	$8,605,930	$698,508	$4,179,403	$1,698,656	$660,515	$829,523
2001	$3,778,924	$9,138,821	$665,377	$5,007,674	$1,799,329	$879,462	$737,115**

* Does not include expenditures for case management services
**Indicates growth percentage from 1997 through 2001

ALTCS / HCBS Spending for the ALTCS HCBS program (LTC services only) has grown 82% in the last five years. The figures below represent expenditures for all services as reported by the EPD Program Contractors. See page 26 for a graph demonstrating expenditures by service.

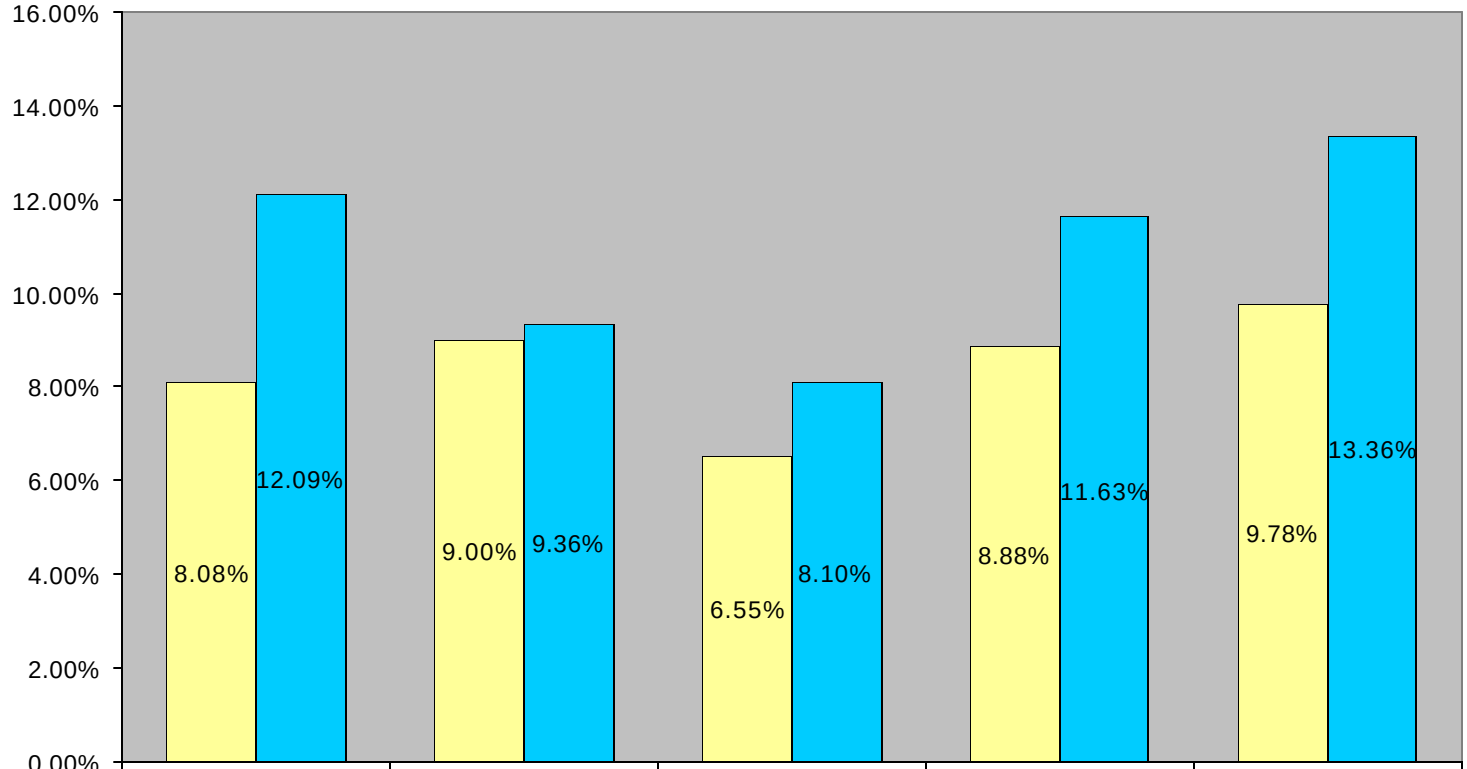


ALTCS / HCBS The increases in expenditures in the ALTCS HCBS program are reflective of the increases in enrollment, increases in utilization of services, and increases in rates for the program. The table below lists the total increases in expenditures from 1997 to 2001.

Service (Excludes Case Management)	% of Growth: FFY 1997 to SFY 2001
Home Health Services (RN & HHA)	80%
Attendant Care	70%
Home Delivered Meals	120%
Housekeeping	20%
Personal Care	41%
Other (Adult Day Health, Environmental Modification, Alternative Residential Settings)	207% (Attributable to Alternative Residential Settings)
Respite Care	78%

ALTCS / HCBS The following graph (page 25) illustrates that the annual growth in total ALTCS capitation dollars has consistently been lower than the sum of annual enrollment and inflationary trends. This is due to the cost savings achieved by increasing the number of members placed in their own homes, or in other alternative settings that are more cost effective than nursing facility placements.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ELDERLY AND PHYSICALLY DISABLED CAPITATION DOLLARS PAID



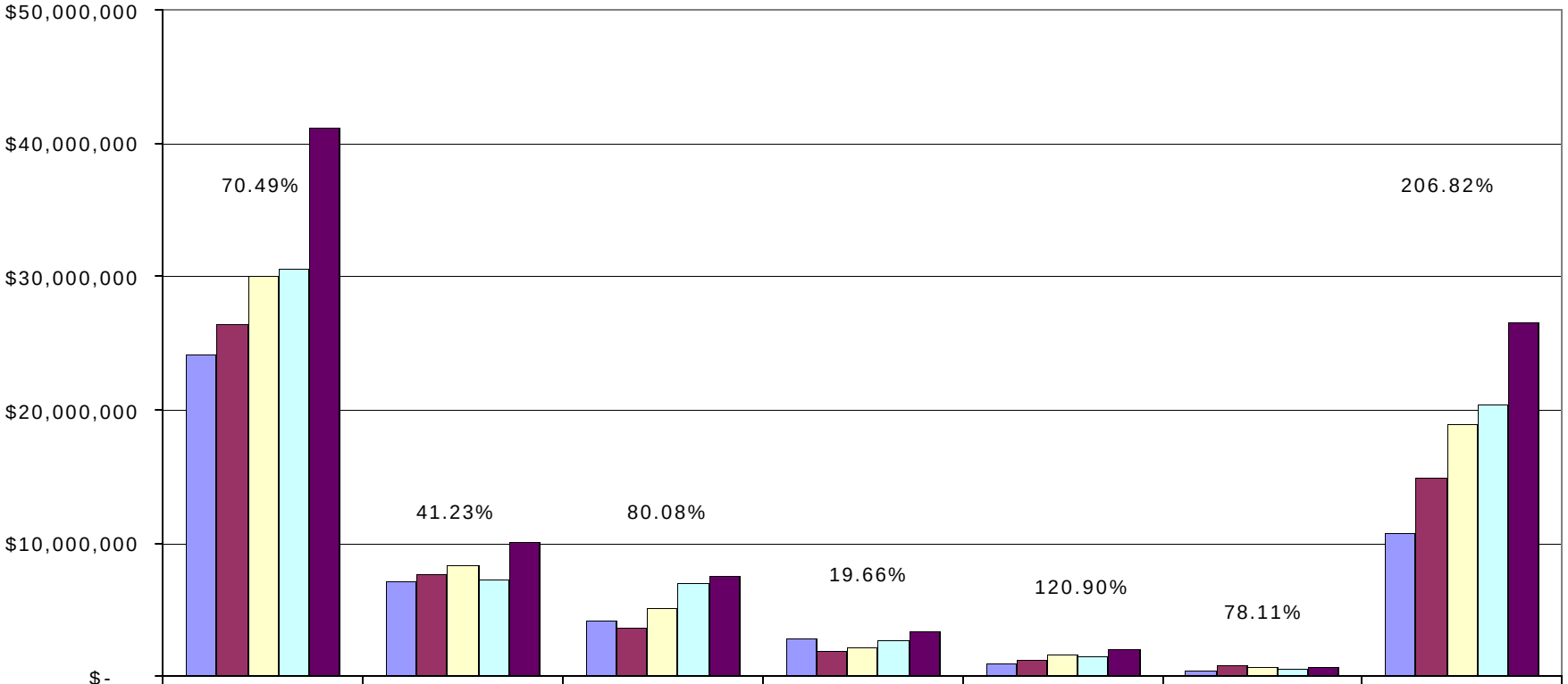
	YR 96-97	YR 97-98	YR 98-99	YR 99-00	YR 00-01
Capitation Growth %	8.08%	9.00%	6.55%	8.88%	9.78%
Enrollment and Inflation % Total	12.09%	9.36%	8.10%	11.63%	13.36%
EPD Enrollment Growth %	6.15%	5.87%	4.30%	7.07%	8.64%
Inflation Growth %	5.94%	3.49%	3.80%	4.56%	4.72%

Capitation Growth % Enrollment and Inflation % Total

ALTCS HCBS PROGRAM

State-Wide Expenditures by Service 2001

(As reported by Program Contractors)



	Attendant Care	Personal Care	Home Health	Homemaker	Home Del. Meals	Respite	Other
1997	$24,168,369	$7,133,378	$4,153,775	$2,837,652	$923,377	$362,509	$10,763,953
1998	$26,389,961	$7,685,142	$3,570,080	$1,908,316	$1,282,218	$754,429	$14,889,185
1999	$30,022,152	$8,373,212	$5,152,253	$2,162,113	$1,659,547	$614,431	$18,904,681
2000	$30,601,398	$7,278,661	$7,018,179	$2,656,813	$1,552,665	$513,567	$20,451,013
2001	$41,199,609	$10,055,539	$7,566,711	$3,396,803	$2,056,607	$663,501	$26,613,200

*Note: "**Other" includes adult day health care, environmental modification, and alternative residential settings***

Chapter 5: What Have We Accomplished?

Introduction

Since the second HCBS report was published in 2000, the agencies have been proactive in dealing with some of the issues noted in the previous and current report. The "Fast Facts" stated earlier in the document provide a summary of agency activity. Also of note is the formation of the "Tri-Agency Committee" comprised of AHCCCS, DES and ADHS to deal with long term care issues. This report is now produced under the auspices of the Tri-Agency Committee.

Fast Facts

AHCCCS

AHCCCS has established guiding principles (see Attachment D) to support the ability of individuals to reside in their own home or an alternative community based setting. AHCCCS has also put these principles into practice by emphasizing the development and maintenance of services and settings that support the growth in the percentage of consumers who are able to live in the community.

Labor Force Forum

With the support of the Governor's Office, AHCCCS planned and hosted a labor force forum in Maricopa County to collaborate with providers, government and educational entities in identifying ways to expand the current network of paraprofessional HCBS providers. An abundance of information was shared among the participants.

Member - Provider Councils

AHCCCS has worked with its program contractors to establish member-provider councils to promote a collaborative effort to enhance the service delivery system in local communities.

Consumer Expectation/Choice Grant

AHCCCS received a two-year grant from the Flinn Foundation for a research effort called Consumer Expectations Regarding Expanding Choices. The primary goals were to understand how Baby Boomers view the current long term care system in Arizona, what services and programs are important to them, and to assess current consumer satisfaction with the ALTCS program in Maricopa County before and after being given a choice of program contractors. The first reports were published mid-2001. A copy of the reports can be found at www.ahcccs.state.az.us/services/ltcbroch/Reports/LTCBrochReports.htm. The final phase of this project began in September 2001 and the final reports are expected to be published mid-2002.

Alzheimer's Pilot Program

Another key program implemented by AHCCCS is the Alzheimer's Pilot Program. In 1999, the Arizona Legislature authorized the second phase of a previously approved demonstration project, called the Alzheimer's Treatment Assisted Living Facility Demonstration Pilot Project. This legislation allows ALTCS to pay qualifying assisted living providers to care for ALTCS members with dementia-related diagnoses. The changes became effective October 1, 2001 and extend the pilot to October 1, 2005.

Continued on next page

DES

Family Caregiver Support Program

The Older Americans Act Amendments of 2000 established a new program, the National Family Caregiver Support Program. The program calls for all states to work in partnership with Area Agencies on Aging and local community service providers for implementation. Arizona received an allocation of $1.9 million to implement the Arizona Family Caregiver Support Program that provides five basic services for family caregivers, including:

- Information to caregivers about available services;
- Assistance to caregivers in gaining access to supportive services;
- Individual counseling, organization of support groups, and caregiver training to assist the caregivers in making decisions and solving problems relating to their caregiving roles;
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by the caregivers.

A Family Caregiver Support Program Planning meeting was held February 2001 to identify implementation strategies of Arizona's Family Caregiver Support Program. Following this planning meeting, the Aging and Adult Administration began developing programmatic policies and procedures and creating service specifications. Area Agencies on Aging developed Family Caregiver Support Program implementation plans that capture the unique needs of their respective planning and service areas.

Alzheimer's CARE Program

Arizona is one of 16 states to participate in the second phase of the Administration on Aging Alzheimer's Disease Demonstration Grants to States. The Aging and Adult Administration, in partnership with the Area Agency on Aging, Region One and the Arizona Chapter of the Alzheimer's Association, implemented the Alzheimer's Caregivers Are Really Extraordinary (CARE) Program in June 2001. The purpose of the program is to provide education, outreach, and direct services to the underserved Hispanic population in outlying areas of Maricopa County and the Native American population in the rural communities of Northern Arizona. The primary objectives of the program are:

- To expand and develop culturally sensitive and linguistically appropriate material for caregivers;
- Increase community awareness; and
- Increase the availability and use of respite.

NMHCBS Assessment Revisions

The Aging and Adult Administration held bi-monthly meetings with the Area Agencies on Aging and their case management providers to review and revise the Arizona Standardized Client Assessment Plan (ASCAP). The meetings began in August 2000 and were held over the next year and a half. Client information was updated to reflect a more social service perspective. Behavioral health and caregiver related questions were added to the ASCAP. Form and mainframe system changes are in the process of being revised for implementation in July 2002

Continued on next page

ADHS

ADHS has also recently joined forces with AHCCCS and DES in publishing the third biannual HCBS Report.

ADHS has established the Healthy Aging 2010 project to promote health and maintain the quality of life for older adults in Arizona. The Healthy Aging 2010 project shares the vision of using collaborative planning and participation with all local, county, tribal and state agencies that seek to promote the health and quality of life for all Arizonans.

Part of the Healthy Aging project will include the development of a state plan for health promotion for older adults using the national Healthy People 2010 and the state Healthy Arizona 2010 planning agendas as frameworks. During the planning process, which included input from leaders in all sectors as well as community members, objectives were established and strategies identified for health improvement activities in communities across the state. Using a similar structure and process, the Healthy Aging 2010 plan will provide information on successful initiatives and strategies being used in communities throughout Arizona to promote healthy lifestyles and maintain optimal levels of activity and well being in older adults. The Healthy Aging plan can foster collaborative projects with the community, resource assessment and development of links across government agencies, non-profit, and private community based programs as they relate to older adults in Arizona.

Continued on next page

Collaboration

The three agencies are working collaboratively on many projects:

Tri-Agency Committee

- Published the third biennial Community Based Services and Settings Report.
- Coordinated long term care investigations and staff training.
- Developed key contact list for HCBS Agency contacts within the three agencies.
- Researched information most important to consumers, and implemented changes to agency websites to make key information about aging services easily accessible and consumer-friendly.

The Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development
The purpose of this committee is to define critical policy concerns and emerging issues regarding long term care and caregiving. Another goal of the committee is to develop cost-effective strategies to promote and encourage workforce development that supports and strengthens family and informal caregiving as a key component of long term care. A written report of recommendations will be submitted to the President of the Senate. The committee is comprised of senators, state agencies, providers, and advocates. AHCCCS, ADHS, and DES have representatives on this committee.

Olmstead Plan
The Olmstead Plan is a public planning process to identify areas for future endeavors to improve opportunities for consumers to live in the most integrated setting possible.

Staff from AHCCCS, DES/Division of Developmental Disabilities (DDD) and ADHS/ Division of Behavioral Health Services (DBHS) met for one year (mid 2000-2001) to develop Arizona's Olmstead Plan. The process included statewide councils that represented a broad range of constituents as well as interested consumers and advocacy groups. The Olmstead plan is available for review on all three agency web pages.

Interagency Council on Long-Term Care
The Council was created by law in 2001 to address long term care issues for both the elderly and persons with physical or developmental disabilities. The Council is currently defining its scope and future activities.

Implications

Agencies have acted on the findings published in the report issued in October 2000, and are committed to sustaining the innovative process development needed to continue and improve the efforts.

Chapter 6: Where Do We Go From Here?

Introduction

This report documents the growth in and the demand for HCBS in Arizona. It also shows an age shift in population. With the growth of the older adult population, the associated trend of more demand for community based services and settings will continue. This trend requires responses from all sectors (private, nonprofit and public) in the State that focus on:

- Maintaining optimal levels of health and well being;
- Obtaining adequate knowledge and understanding to effectively manage chronic conditions and disabilities; and
- Accessing services in an appropriate and timely manner.

To meet the demands for HCBS, there are roles for older adults and families, the business community, and community organizations as well as government agencies.

Fast Facts

- According to the 2000 census, Arizona had the third highest increase (39%) in the older population in the nation.
- Arizonans may be living longer with lower death rates for some diseases but are not necessarily more healthy or able to be active and independent in their old age. Chronic diseases are the most prevalent, and yet preventable health problem in our state.[23] An increased focus on chronic disease management and healthy aging will help to lessen the impact of the growing population on the long term care system.
- Among the older population, those over 85 years and older showed the highest percentage increase. At this age, the need for supportive services generally increases.
- Nationally, the percentage of individuals 65 years and older living in nursing homes declined from 5.1% in 1990 to 4.5% in 2000. The largest decline was in the population over 85. This population made up 24.5% of the nursing home population in 1990 and declined to 18.2% in 2000. Persons 65 and older are choosing to remain in their communities.
- There is a national push to make HCBS services available to a larger population. Executive Order 13217 directs six federal agencies to, "evaluate the policies, programs, statutes, and regulations of their respective agencies to determine whether any should be revised or modified to improve the availability of community-based services for qualified individuals with disabilities"[24]

Continued on next page

[23] Public Health Services, Bureau of Public Health Statistics (2000); Arizona Health Status and Vital Statistics, 2000

[24] U.S. Department of Health & Human Services (2001); Delivering on the Promise: Preliminary Report (Introduction)

Continued and Future Initiatives

AHCCCS and DES/A&AA will continue to provide the management of HCBS programs for the elderly and physically disabled throughout the State. ADHS will continue to provide regulatory oversight for assisted living homes and assisted living centers.

Government agencies also can function as catalysts and partners with businesses, nonprofit organizations, faith communities, and community citizen groups to assure that the issues related to older adults and physically disabled are identified and addressed effectively. The following continuing and future initiatives demonstrate Arizona's commitment to addressing the challenges of long term care in the coming years:

- Completion of the final phase of the Consumer Expectations Regarding Expanding Choices project that assesses consumer satisfaction with long term care services since multiple program contractor choices became available in Maricopa County (October 2000);
- Continued collaborative efforts of the Caregiver and Workforce Development Committee;
- Continue to work in partnership with the Area Agencies on Aging and local community service providers to implement the Arizona Family Caregiver Support Program;
- Ongoing pursuit of objectives as outlined in the Olmstead Plan;
- Continuation of Healthy Aging 2010 Project; and
- Continue to work with members of the Interagency Council on Long Term Care to further define its scope and goals.

Implications

As the growing demand for HCBS is addressed by the AHCCCS, DES, and ADHS agencies in the forms of regulation, funding, collaboration with other entities and the provision of services, a focus on the health needs that drive the demand of services is appropriate. Chronic diseases have largely replaced communicable diseases as the leading cause of death and disability in the nation.

- In Arizona, the four leading causes of death in older adults 65 years and older are chronic diseases and include diseases of the heart, cancer, stroke and chronic obstructive pulmonary disease.
- Nationally, the cost of treating and living with a chronic disease is estimated in excess of $325 billion annually.
- Although hereditary and environmental factors impact health status, it is estimated that 50% to 60% of the primary influences for the development of chronic disease are choices in lifestyle behavior. For example, lifestyle choices related to physical activity, nutrition, management of stress, and the use of tobacco and alcohol will affect the chances of developing a chronic disease or, if a chronic disease is already present, how well the disease is managed.

At the present time and certainly in the future, addressing the lifestyle choices that increase risk of chronic disease will be as important as assuring the quality and accessibility of needed health services.

Continued on next page

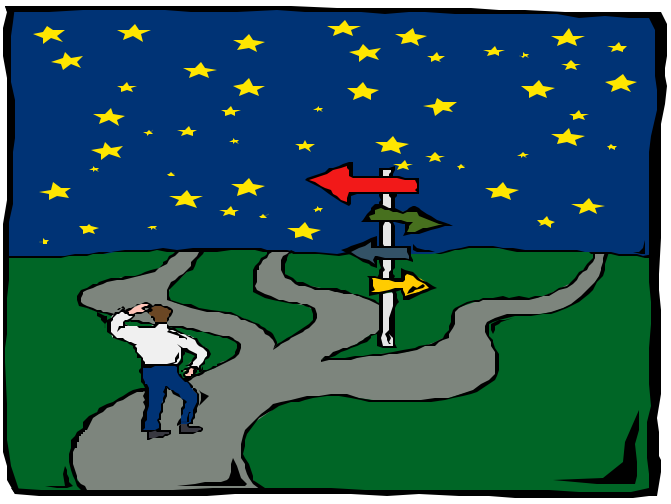
Implications, Continued

The continuing shortage of professional and paraprofessional caregivers in Arizona will reach emergency levels without innovative interventions and collaboration by the state agencies, lawmakers, advocacy groups, and medical organizations. Some of the reasons Arizona is facing this crisis include:

- Society has stigmatized the formal caregiver positions as employment for people who are disadvantaged economically and have low levels of education;
- Competition from other service industries that recruit entry level positions;
- The supply of workers has declined due to low birth rates in the baby-boom generation; and
- Low wages and lack of benefits such as health insurance and retirement plans.

Nationally there is an increasing interest in consumer-directed care, not just for the younger consumer, but for the older as well. "[T]here are still concerns about whether older beneficiaries want to and are able to manage their own services, and the prevalence of cognitive impairment among the elderly population. One key advantage to the states of consumer-directed home health care is that per-person costs are much lower than for agency-directed care due to the absence of administrative overhead and fewer worker benefits."[25]

It is clear that living in the community is the preferred choice for older adults and individuals with physical disabilities in Arizona. The challenge facing Arizona will be in the continued development of the capacity to provide quality community based services and settings, maintain adequate choices of qualified caregivers and sustain adequate financial resources (both private and public monies) to pay for community based services and settings.



[25] The Urban Inststute, Long Term Care for the Elderly: www.urban.org/health/long-term-care

Appendix A: Definitions

*Starred Items mean that both the NMHCBS and ALTCS programs provide this service.

***Adult Day Health:** A program that provides planned care and supervision, recreation and socialization, personal living skills training, group meals, health monitoring and various preventive, therapeutic and restorative health care services.

Arizona Long-Term Care System (ALTCS): ALTCS is a program under AHCCCS that delivers long-term, acute, behavioral health, and case management services to members, as authorized by A.R.S. § 36-29321. Long-term care services include both nursing facilities and HCBS.

***Attendant Care:** A service provided by a trained attendant for members who reside in their own homes and which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development.

Case Management (ALTCS/HCBS): The process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained, and monitored for individuals eligible for ALTCS services (A.A.C. R9-28-510). The process integrates the ALTCS member's and the case manager's review of the member's strengths and needs resulting in agreed upon appropriate and cost effective acute and long term care services.

Case management (NMHCBS): The assessment and development of an individualized service plan through which the eligibility of an individual is determined, appropriate services or benefits are identified, planned, reported, monitored or terminated, and follow-up is provided if and when appropriate (A.R.S. § 46-191.3).

Chore (NMHCBS): A service that provides heavy indoor cleaning and may include designated outdoor tasks.

***Emergency Alert System:** A service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone.

Healthy Aging 2010 Project: The Healthy Aging project includes the development of a state plan for health promotion for older adults using the national Healthy People 2010 and state Healthy Arizona 2010 planning agendas as frameworks. Health objectives will be established and strategies identified for health promotion activities in communities across the state.

***Home Delivered Meals:** A service that provides a nutritious meal containing at least one-third of the federal recommended daily allowance for the member, delivered to the member's own home.

Home Health Aid (NMHCBS): This service provides intermittent health maintenance, continued treatments or monitoring of a health condition, and supportive care for daily living activities at the individual's place of residence.

Home Health Services: (ALTCS): Includes Home Health Aid and Home Nursing (Intermittent or Continuous). Part-time or intermittent care for members who do not require hospital care. Service is provided under the direction of a physician to prevent re-hospitalization or institutionalization; may include nursing, therapies, supplies and home health aid services.

Services, Continued

***Homemaker:** A service that provides assistance in the performance of routine household activities such as shopping, cooking and running errands. (ALTCS includes chore services within homemaker services)

Home Modification (ALTCS): A service that provides building specification or items which allow members to function as independently as possible in their own homes.

Home Nursing (NMHCBS): This service provides intermittent skilled nursing services in the individual' s place of residences. Skilled nursing services may include health maintenance, continued treatments, or supervision of a health condition.

Non-Medical Home and Community Based Services (NMHCBS): A comprehensive, case managed system of care provided to a functionally disabled individual in the individual' s home or community that supports the role of family and caregivers as part of the service plan. The service plan may include personal care, housekeeping, chore services, adult day health care, respite, and home delivered meals, as well as health care services and other related health and social services that are a necessary, but subordinate, part of the service plan (A.R.S. § 46-191.7).

***Personal Care:** A service that provides assistance with personal physical needs such as washing hair, bathing and dressing.

Respite Care (ALTCS): Includes group care, in-home and continuous respite care. A service that provides short-term care and supervision to relieve primary caregivers. It is available for up to 24-hours per day and limited to 720 hours per year. Group respite is similar to Adult Day Health and is provided as a substitute when Adult Day Health services are not available.

Respite Care (NMHCBS): This service provides short-term care and supervision to relieve primary caregivers or clients. This service may be available on a 24-hour basis.

Transportation: A service that provides non-emergency transportation to medical, social or related activities.

Settings Limited to ALTCS

Adult Foster Care: An ALTCS HCBS approved alternative residential setting that provides room, board, supervision and coordination of necessary services within a family type environment for up to four adult residents.

Assisted Living Home: An ALTCS approved alternative residential setting that provides resident rooms to ten or fewer residents.

Assisted Living Centers- Units Only: An ALTCS approved alternative residential setting that provides a private apartment, unless otherwise requested by a resident, that includes a living and sleeping space, kitchen area, private bathroom and storage area.

Behavioral Health Level II & III: A behavioral health service agency licensed by ADHS to provide a structured residential setting with 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level I behavioral health facility.

Appendix B: HCBS Programs: Similarities and Differences

NMHCBS

The Aging and Adult Administration (A&AA) within the Arizona Department of Economic Security (ADES) is responsible for delivery of Non-Medical Home and Community Based Services (NMHCBS) for individuals 60 years of age or older or disabled who meet the eligibility requirements. The program receives state, federal, and local funding. There are eight Area Agencies on Aging (AAA) and one prime sponsor (non-AAA entity) that serve individuals in Arizona. AAAs utilize a case management system to determine need and authorize services. The AAAs are responsible for contracting with providers for the direct provision of services.

The program provides home delivered meals, in-home care, respite, and adult day health care services. On reservations, consumers receive home delivered meals and respite care via the AAA. All consumers live in their own home. Other in-home services provided to reservations are through federal funds that are given directly to the tribes. Services are limited by available federal and state funding.

ALTCS

The Arizona Health Care Cost Containment System (AHCCCS), Arizona Long-Term Care System (ALTCS) is funded by federal, state, and county monies. ALTCS serves the elderly, physically disabled, and developmentally disabled determined to be at an institutional level of care and financially eligible. Acute (medical), institutional, case management, home and community based services, and behavioral health services are all covered services under ALTCS. Members are enrolled with AHCCCS contracted managed care organizations (program contractors). There are eight program contractors including the Arizona Department of Economic Security / Division of Developmental Disabilities (ADES/DDD). The eight program contractors provide case management and services in designated geographic areas.

Case Management

For both programs, case management is a central cog and key service in the coordination of hands-on services. In the NMHCBS program, where funding is limited, the case manager plays a critical role in assessing finances and assisting the consumer, when possible, in the private purchase of a service, or perhaps, community scholarship funds for the service. As a Medicaid program, ALTCS has prescribed financial, functional, and medical criteria. Eligibility is determined by AHCCCS prior to the consumer receiving a case manager. The ALTCS program is required to provide for the needs of all members in the community up to the cost that would be spent if the consumer were in the facility.

The case manager will make every effort to foster a person-centered approach and respect maximum member/family self-determination while promoting the values of dignity, independence, self-determination, individuality, privacy, and choice. Case management begins with respect for the member' s preferences, interests, needs, culture, language, and belief system.

Continued on next page

Appendix B: HCBS Programs: Similarities and Differences , Continued

Case Management, Continued

The involvement of the member in strengths and needs identification and in decision making is a basic tenet of case management practice. Care plan development is a shared responsibility with the member/family/significant others input seen as key to the success of the plan. The member/family/significant others are partners with the case managers in the development of the plan with the case manager in a facilitating mode.

Case managers are expected to use a holistic approach regarding the member assessment and needs, taking into account not only covered services but also other needed community resources as applicable. Case managers are expected to:

- Provide adequate information and teaching to assist the member/family in making informed decisions and choices;
- Provide a continuum of service options that support the expectations and agreement established through the care plan process;
- Integrate services available throughout the community;
- Advocate for the member, family or significant other as the need occurs;
- Allow the member, family, or significant other to identify their role in interacting with the service system;
- Provide members with flexible and creative service delivery options;
- Provide necessary information to providers about any changes in consumer's functional level to assist the provider in planning, delivering, and monitoring services; and
- Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the consumer.

Comparisons

Categories	NMHCBS	ALTCS HCBS
Eligibility	Meets functional/medical criteria: either 60+ or physically disabled	Meets financial, functional, and medical criteria
Funding Availability	Limited to federal and state allocations and community contributions– Not an entitlement	Medicaid funded program (federal, state, and county) - Entitlement based on eligibility
Case Management	No prescribed ratio of case manager to consumer. Caseload is usually a minimum of 100+ per case manager. Visits at 3 to 6 month intervals with SPP direct pay and wait list members with alternative visit intervals.	Caseloads have prescribed ratios. HCBS 1 to 48 with three month interval visits and Skilled Nursing Facility = 1:120 with 6 month intervals.
Services		
Acute Care	No	Yes
Behavioral Health Care	No	Yes
Adult Day Health Care	Yes	Yes
Attendant Care	Yes, limited	Yes
Home Health Aid	Yes	Yes
Home Nursing	Yes/Limited	Yes/Extensive
Housekeeping/Chore	Yes	Yes
Home Delivered Meals	Yes	Yes
Personal Care	Yes	Yes
Respite Care	Yes	Yes
Home Modification	No	Yes
Alternative Res. Settings	No	Yes
Waiting list for services	Yes (629), as of June 30, 2001	No

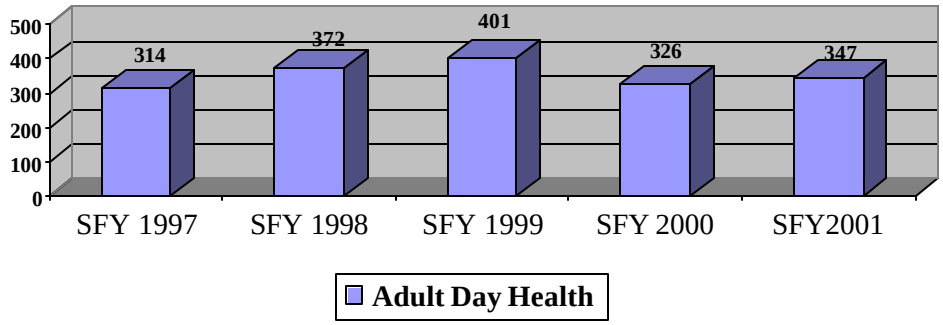
Appendix C: NMHCBS Enrollment Detail

Introduction

The following series of graphs demonstrates changes in the number of consumers who utilized the individual NMHCBS services over time. See Chart on page 12 for further explanations regarding the charts below.

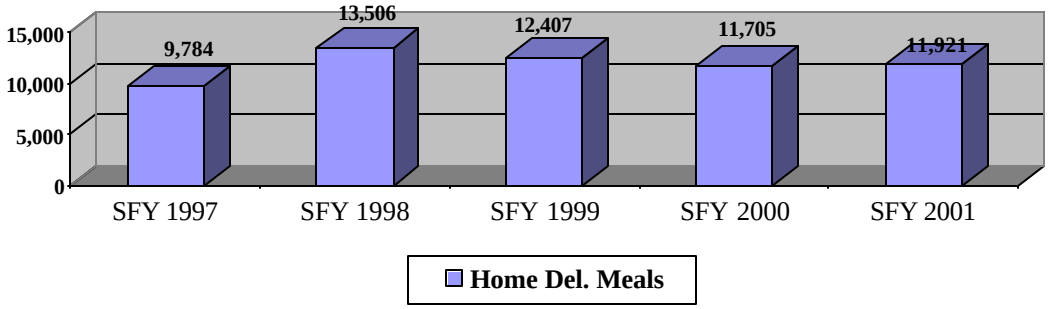
Adult Day Health (ADH)

The number of individuals utilizing ADH services has remained relatively consistent over this five year period of time.



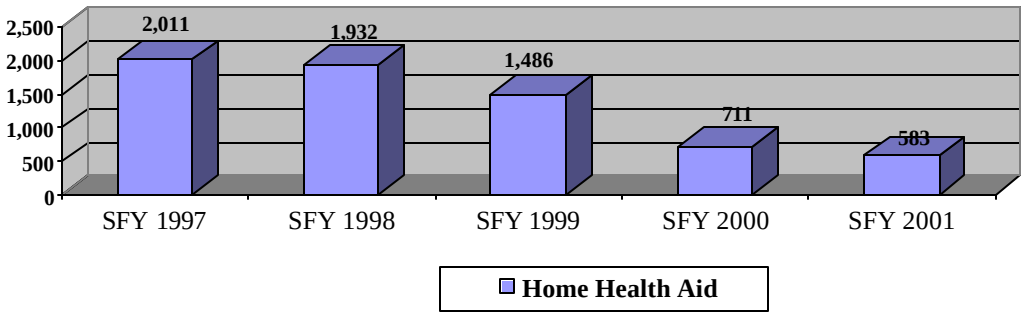
Home Delivered Meals (HDM)

The number of individuals utilizing HDM services has increased by 22% from 1997 to 2001.



Home Health Aid (HHA)

The number of individuals utilizing HHA services has declined by 71% from 1997 to 2001.



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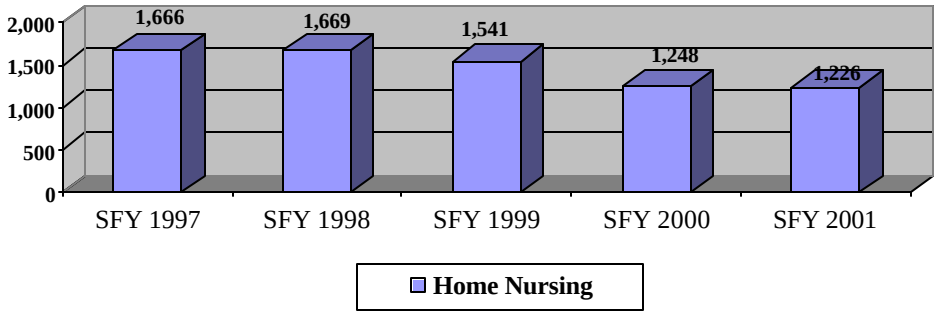
Appendix C: NMHCBS Enrollment Detail, Continued

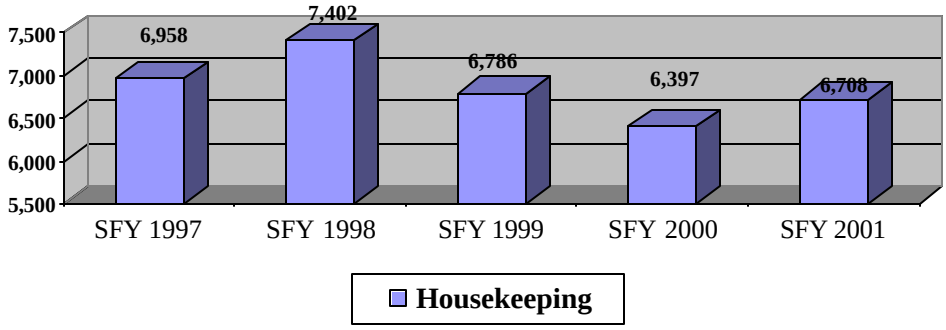
Home Nursing (HRN)

The number of individuals utilizing HRN services has declined by 26% from 1997 to 2001.



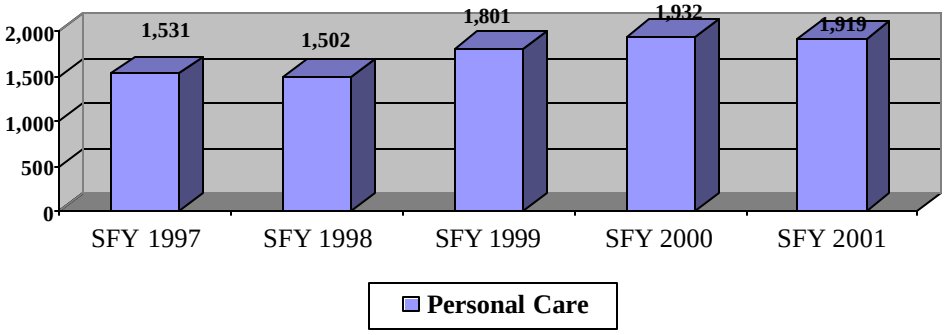
Housekeeping (HSK)

The number of individuals utilizing HSK services has decreased by 4% from 1997 to 2001.



Personal Care (PC)

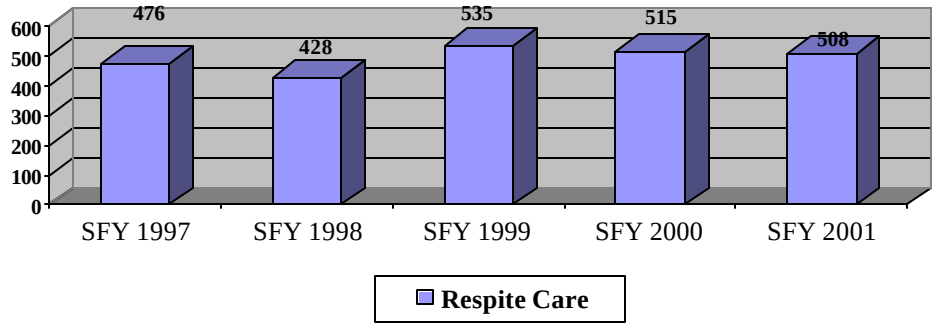
The number of individuals utilizing PC services has increased 25% from 1997 to 2001.



Appendix C: NMHCBS Enrollment Detail, Continued

Respite Care (RC)

The number of individuals receiving RC services has increased by 7% from 1997 to 2001.



Appendix D: ALTCS Guiding Principles

Principles:

- Member-Centered Case Management

  The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

- Consistency of Services

  Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining their highest level of self-sufficiency. Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and the Program Contractor.

- Accessibility of Network

  Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations, or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed with the Program Contractor's knowledge that a member's needs are not limited to normal business hours.

- Most Integrated Setting

  Members are to be maintained in the least restrictive setting. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.

- Collaboration With Stakeholders

  The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers, and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented, and evaluated for continuous improvement.

Appendix E: Obtaining Copies of the Report

Availability

This report can be obtained through following options:

1. Viewing the Arizona Health Care Cost Containment System (AHCCCS) website: http:\\www.ahcccs.state.az.us;

2. Viewing the Arizona Department of Economic Security (ADES) website: http:\\www.de.state.az.us;

3. Viewing the Arizona Department of Health Services (ADHS) website: http:\\www.hs.state.az.us;

4. Writing to:
   Claire Sinay, Federal/State Policy Manager
   Office of Policy Analysis and Coordination
   801 East Jefferson Street, MD 4200
   Phoenix, Arizona 85034
   Fax Number: (602) 256-6756
   cxsinay@ahcccs.state.az.us; or

5. Calling:
   Lisa Calcagni, AHCCCS/Administrative Assistant, at (602) 417-4272.